CONNECTICUT HEALTH INSURANCE EXCHANGE PLANNING GRANT STAKEHOLDER MEETING INSURANCE PLANS

DATE: May 16, 2011

LOCATION: Office of Policy and Management, 450 Capitol Avenue

INVITED TO ATTEND:
Aetna
Anthem Blue Cross Blue Shield
CIGNA Healthcare of CT
Community Health Network
ConnectiCare, Inc.
UnitedHealth Group
Wellcare of Connecticut, Inc.
Celtic
American Republic
Golden Rule
John Alden
Trustmark Life
Trustmark
Time

MEETING ATTENDEES:
Kate Wade, Vice President, State Government Affairs, CIGNA
Michelle Girton, Actuarial Director, CIGNA
Kathy Vaccaso, Vice President, Healthcare Reform, CIGNA
Tim Meyer, Vice President, Government Affairs, NE Regional, Aetna
Karen Cwirka, Associate General Counsel, ConnectiCare, Inc.
Janice Perkins, Director, Government Relations, ConnectiCare, Inc.
Michelle Zettergren, Vice President, Sales and Marketing, ConnectiCare, Inc.
Candy Krebs, Sr. Business Consultant, Aetna
Darrel Farkus, Vice President, Business Development, UnitedHealth Group
John E. Fleig, Jr., Chief Operating Officer, Mid Atlantic Health Plan, UnitedHealth Group
James J. Auger, Jr., Vice President, Anthem Blue Cross Blue Shield
Daniel Trencher, Staff Vice President, Corporate Strategy, Anthem Blue Cross Blue Shield
Philip Anderson, Director, Regulatory Affairs, UnitedHealth Group
Martha Temple, President, New England Market, Aetna
Christine Cappiello, Director, Government Relations, Anthem Blue Cross Blue Shield
Keith Stover, Lobbyist, Robinson & Cole, LLP

Background

The public engagement plan for Connecticut (the State) in planning for an Insurance Exchange consists of public forums held throughout the State as well as stakeholder meetings organized by professional group category. Over 85 organizations were invited to attend a stakeholder meeting to discuss Exchange topics such as structure, operations, market reforms, accountability, transparency, and sustainability. Questions were sent to each organization prior to their meeting. The feedback the State received from these questions was used as the framework for the discussion. Meetings were conducted by a neutral facilitator and recorded/transcribed. This document reflects an integration of initial written comments from the invited organizations listed above, as well as discussion from the meeting. It is intended as a summarized snapshot of the initial perspective(s) of the groups that participated. **It is not intended to represent final thoughts or positions**.

ESTABLISH A RESPONSIVE AND EFFICIENT STRUCTURE	
Should Connecticut consider joining a multi-state Exchange?	
Probably not.	• Could allow sharing of administrative costs but there are too many drawbacks • A state-specific Exchange may be more responsive to CT's needs • Could be complex • Not as accountable to citizens and taxpayers • Unclear what benefits would be • Consideration of state nuances should be primary driver • Give consideration to state laws, consumer protections
Should CT administer the individual and small group markets separately or jointly?	
Keep the risk pools separate.	• Differences in rating exist • Should allow plans to sell in either or both markets • If you have carriers who want to play either individual or small employer, you could have gaming of the system • If you find that you have more selection in the individual marketplace and you pool the risk pools, you are asking small businesses to absorb that cost – is it fair to ask small businesses to take on additional risk beyond the risk that they put into the pool?
Possibly share IT and administrative functions.	• Avoid duplicating processes. Consider a shared website and capabilities, and exchanges of enrollment information or eligibility information, in order to avoid setting up two completely different feed types with the new standards • The individual and small group populations often require different types of support and benefit designs • Huge challenge for the states to make sure the exchanges are fully financially self-sufficient in one year, so a shared infrastructure is going to be the most efficient
What employer size should Connecticut allow into the Exchange?	
Limit to 50 until 2016	• Minimize disruption • The markets are very different • Walk before you run – optimize systems and address issues • Expanding will require statutory changes prior to expansion • Businesses with 51 plus employees are more sophisticated and likelier to self-fund – why change that if it is working? • The needs are much different and the opportunities are different, and if the rules are different outside the Exchange versus inside the Exchange, there may be a migration to more groups looking at considering self-insuring and leaving the risk inside the Exchange
Do not allow employers greater than 100.	• These employers have very different needs • The needs driving the ACA are individuals and small businesses, not this population • Small businesses are more highly reliant on assistance like the Exchange but as you get up to 55, 75, 100, 500 lives, businesses have more of an ability to develop internal capabilities to deal with these issues and as a consequence are less reliant on or less in need of this sort of assistance • Larger employers will more often have employees outside of the state of Connecticut in multiple states and that would just make it difficult on the employer as well as on the Exchange • There is a fair amount of angst amongst the large employers about what it is going to mean to deal with multiple exchanges, particularly the administrative burden

ADDRESS ADVERSE SELECTION AND THE EXTERNAL MARKET	
Should CT allow a dual market, a hybrid market, or should it require that all individual insurance be sold through the Exchange?	
Dual market.	• Allows choice • In terms of satisfying the individual mandate to carry insurance, there is not a requirement that the individual purchase insurance on the Exchange; they can purchase something *off* the Exchange • Robust marketplace • Required by ACA (this is the intent of the ACA)
May be affordability issues on Exchange.	• Based on the richness of the plan designs mandated in the ACA, when the actual values are significantly richer than the plan designs that individuals typically purchase today, it will become an affordability issue for the non-subsidized marketplace to purchase on the Exchange
Should CT implement any additional mechanisms to mitigate adverse selection?	
Level playing field.	• Same rules in and out of Exchange • Establish consistency: a shared risk pool, the same rating rules, etc. • Address out-of-state insurers gaming the market by offering products exclusively outside the Exchange with plans that selectively target better risks[1] • Restrictions on open enrollment periods (individual market) • Minimize disruption • No exemptions from certification for any type of plan
Standardized enrollment and other rules.	• Individual = single, annual, and special enrollment events • Small group = continuous, with rules, except for sole proprietor which is same as the individual • Employer selects plans employees can choose from • Allow a change of just one level per year (of the "metals") so consumers do not buy cheap plans, then get sick and buy expensive plans, jump down the next year to cheap plans again • Effective risk adjustment and reinsurance • Maintain CSEHRP for the Exchange
Not necessary.	• ACA provisions make additional rules unnecessary • Minimize administrative burden • Is adverse selection really an issue if your pools are combined between in and out of the Exchange

SIMPLIFY HEALTH INSURANCE PURCHASE	
What issues should Connecticut consider in establishing a Navigator program?	
Neutral and impartial.	• Cannot charge fees or be reimbursed • Impartial as to health plans and providers
Confirmation of capabilities.	• Experience of existing entities in outreach and education • Skills and knowledge needed to access uninsured populations • Ensure working knowledge of and familiarity with health plans, similar to certification process for brokers • Licensed by CID as necessary • Huge communication hurdle in making sure the different groups understand and can accurately and effectively communicate

[1] Clarification requested. Comment made by Tim Meyer of Aetna: "Please strike third bullet under level playing field on page 3 or rewrite it to make it more clear."

SIMPLIFY HEALTH INSURANCE PURCHASE	
What issues should Connecticut consider in establishing a Navigator program?	
Clear responsibilities.	• Two roles: the first is in figuring out eligibility for subsidies, the second is in educating about enrollment • The first question people are going to have is – do I qualify for subsidies? – and there is not going to be a lot of interest in learning more generally about the Exchange until that issue is addressed • This conversation just underscores the importance of really having delineated responsibilities between what the Exchange is doing, what the Navigators are doing, and what the brokers are doing
What should Connecticut consider regarding the role of insurance brokers and agents?	
Important role.	• They perform many important functions, not exclusively at the time of sale and renewal but continuously throughout the year • Should continue to play a key role • If you look at the experience on Medicare Part D, people get overwhelmed with the amount of choices. The brokers and agents can continue to play a role in assisting people with their selections • Employers, particularly in that two to 50 space, will continue to be willing to pay for good advice • There will be more pressure for them to produce value
Need price transparency.	• An individual consumer may not understand that when they make an appointment to speak to a broker, that broker has to get paid and where that payment is coming from – that lack of transparency, is going to have to be examined in the future
Address pricing incentives.	• Should be no incentives for them to steer business solely in or out of the Exchange • Health plans should be allowed to set the commissions for in and out of the Exchange

INCREASE ACCESS TO AND PORTABILITY OF HIGH QUALITY HEALTH INSURANCE	
Should CT allow any plan that meets Qualified Health Plan standards to be available in the Exchange, or should CT establish additional requirements? If additional requirements, what would you recommend? What would be impact of those requirements?	
Allow any plan.	• Ensure choice and competition • Avoid being burdensome • The state already regulates insurers and those rules are adequate • In Connecticut there is already a limited number of plans on the small group and individuals market; if you limit it further, you are really limiting competition and choice ultimately for the consumer • You have to get the Exchange up and running – start with a clearinghouse and then evaluate and build, gain some experience and then potentially determine whether or not you want to move down that continuum of becoming a more active purchaser or not • By building a good website you can give consumers good decisions of choice rather than limiting the number of plans; they can begin whittling down the number of plans in a way that is meaningful for them

INCREASE ACCESS TO AND PORTABILITY OF HIGH QUALITY HEALTH INSURANCE	
Should CT consider establishing the Basic Health Program? What would the BHP offer as a tool to facilitate continuity of coverage and care?	
Continue to evaluate this option.	• Evaluate early, as this will impact planning for Exchange • Consider whether funding is adequate • Consider value to consumers, continuity of care • Given small Exchange population, carefully consider unintended consequences • Given the federal regulations we are still waiting for, it is too early to tell
How can CT structure its Exchanges to maximize continuity of coverage and seamless transition between public and private coverage? (E.g. as a person moves from Medicaid, subsidized and non-subsidized markets)	
Inclusive process.	• Private payers are well situated to design programs to ensure continuity of care and healthy outcomes • Dialogue between regulators and insurers to see if collaborative solutions exist • Accept NCQA accreditation • Seamlessness is important but we also must recognize differences in the groups
Start with the basics.	• Get the exchange for the private market up and running successfully and then examine ways to maximize continuity of coverage between public and private coverage
Address churn.	• There is a real concern about individuals moving back and forth between Medicaid and Exchange eligibility–some studies have suggested this will be arduous in terms of administration • The churn factor can be addressed by letting individuals lock in for one, into their eligibility of either Medicaid or the Exchange subsidy • That is a very specialized group of individuals that tend to be older, sicker

ENSURE GREATER ACCOUNTABILITY AND TRANSPARENCY	
What information should CT include for outreach to most effectively engage consumers? How should the information be presented?	
Use varied media.	• Use media appropriate to and selected by the Exchange's target audience • Consider a variety of sources: TV, radio, newspapers, town hall meetings, mobile media • Use the media that consumers use: print or electronic, smart phones, one on one; and filtered how the consumer wants the information filtered
Clear information.	• Same information we have today, but not necessarily using "insurance-ese", using "consumer-ese" instead and providing easy to understand information • Include pertinent dates, key information, vehicles to evaluate offerings, etc. • Provide information on cost and quality to help make informed decisions – report cards
Focus on both markets.	• A good amount of the focus is on the individual market and consumers. There needs to be an increased amount around small businesses since so many do not provide benefits. Keeping small businesses in the process is just as critical

ENSURE GREATER ACCOUNTABILITY AND TRANSPARENCY	
How should Connecticut ensure ongoing feedback and input about accountability, operational issues, and suggested improvements?	
Regular consultation.	• Online survey • Post customer service call • Part of Exchange governance

	• Formal stakeholder consultation • Regular and active consultation in a formal process • Stakeholder advisory role for insurance plans in order to obtain their experience and expertise
Regular reporting.	• Regularly publish information • Reporting & fiduciary accountability, transparency, formal redress process
Build into system.	• Leverage existing CID protections • Exchange governing docs should address these issues
What information, beyond that required under the ACA and implementing regulations, should Connecticut require of plans? How much of this information should be shared with consumers accessing the Exchange?	
Oppose additional requirements.	• Only require additional data that is necessary • Exchange regulations are sufficient; additional regulations would minimize choice, competition, and participation • Additional reporting would increase expenses for plans, regulator and consumers
But if requirements are necessary…	• Leverage existing state regulation • Focus reporting on high value information • Follow national standards for data • Use existing national accreditation such as NCQA or URAC • Provide consistent information relative to offerings marketed on the Exchange

SELF SUSTAINING FINANCING	
How should the Exchange's operations be financed beginning in 2015? How might the State's financing strategies encourage or discourage participation in the Exchange; Affect the reputation of the Exchange, and affect accountability, transparency and cost effectiveness?	
Broad based.	• Grants, fees, assessments, taxes • Providers, plans, employers, agencies, products, and services (tobacco, • tanning, alcohol, junk food, pharma, medical devices) • Advertising on the Exchange • Fees to plans should not be the only source as that may discourage participation • Pricing should be transparent, and excluded from MLR • Limit to minimum amount necessary • Unspent funds must be returned or used in future years • Clear disclosure • The AAC came out with a paper that had a variety of funding suggestions that were very creative
What issues should be considered regarding state requirements for additional benefits above the minimum essential benefits? What funding sources should be considered for the cost of additional benefits?	
Cost.	• Cost to state should be considered • Still needs to be affordable for the individual • Because required to fund by taxpayers, should not add additional benefits • Any benefit offerings above minimum should be at expense of individual • ACA sets strong floor; additional requirements will have unintended consequences of limiting innovation and choice, and hurt affordability

ADDITIONAL EXCHANGE FUNCTIONS	
Are there advantages to limiting the number of plans offered in the Exchange, or is the Exchange a stronger marketplace if it permits "any willing provider" to sell coverage?	
Any willing provider	• Choice, competition, innovation
Beyond the Exchange's minimum requirements, are there additional functions that should be considered for Connecticut's Exchange? Why?	
Start simple.	• Because of complexity, focus on achieving required goals, getting the Exchange up and running smoothly • Functions that should not be managed by Exchanges include: price regulation (function of CID), billing and premium collection, broker commissions
Should CT consider setting any conditions for employer participation in the small group exchange (e.g. minimum percent of employees participating, minimum employer contribution, limits in the range of product benefit values that may be selected by employees, etc)?	
Yes.	• Participation % / Group size • Minimum contribution requirement • Employer choice regarding plan offerings • Require all employees to purchase within one actuarial level
What are some of the initiatives that could maximize flexibility and offer value for small business employers to utilize the Exchange?	
Keep it simple.	• Maintain choice • Offer services to ease admin burden • Ease of access to tax credit • Consider effects of well intentioned regulations that could increase prices and destabilize small group market • Best value is to function effectively and low cost, so focus on implementing requirements of the Exchange only, not additional initiatives
What should be the role of the Exchange in premium collection and billing?	
None / maintain this in plans	• Maintains important connection to members, and plans are able to comply with state requirements • The industry is very effective at billing and collecting – do not add another bend in the pipe that causes additional delays, gets in the way of grace periods, and causes other problems of that nature • For the individual market, billing is another way to reach out and touch our members

ADDITIONAL EXCHANGE FUNCTIONS	
What should be the role of the Exchange in premium collection and billing?	

Yes / this will simplify things	• Billing structure will be more complicated
	• The Exchange will need to:
	  – Act as the " back office" for premium billing, collection and remittance
	  – Split the premium received from employers among different carriers
	  – Have procedures for delinquent collections, termination for non-payment, accounts receivable
	  – Rapidly acquire the skills needed to act as the consolidator – skills include payment methodologies, financial administration for consumer-directed plans, and reconciliations of all receipts and payments with all parties involved environment
	• The Connector, for example, hired a private contractor to perform these functions

	with participating carriers
For employers, it depends on how Exchange rules work.	• Depends on whether we have an employ*er* choice model or an employ*ee* choice model in small group – if the employer is choosing for the employees, the carriers would want to maintain the billing versus with an employee model, Exchange should consider doing billing[2] • In looking at CBIA model for instance, today CBIA takes care of a lot of premium collection and billing so that the companies do not have to get involved in split-billing arrangements
What are all the different data collection and reporting mechanisms that are necessary to operate a transparent and accountable Exchange?	
Timely collection and distribution of data (on web) should include (but not be limited to):	• Membership demographics • Participation rates • Plan selection options • Claim and utilization info • Premium billing • Accounts receivable and outstanding debt • Details on any assessments or fees • Migration reports • Overall experience of the Exchange/carriers • Periodic reports about Exchange activities • Total #of carriers in the Exchange (both for current and next year) • Audited financial reports • Average costs of licensing, regulatory fees and any other payments required by Exchange, and the admin costs • Accurate accounting of all activities, receipts and expenditures • All information required to satisfy internal and external audit activities • National (such as HEDIS or NQF) rating of plans • Standardized data sharing formats

[2] Comment made by Tim Meyer of Aetna: "The three sections on premium billing appear to contradict each other a tad. I realize there was some differences between what ConnectiCare suggested versus us at Aetna but my recollection where we ultimately left this issue in terms of the SG market is that we all agreed that it depends on whether the employer is choosing the plan or whether the employee does (this is precisely how you framed it in the box on page 8 labeled "for employers, it depends on how Exchange rules work)."